Standard Form 93
REV. OCTOBER 1974
GSA/FPMR 101-11B

Approved
Office of Management and Budget No.
0704-0337

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME - FIRST NAME - MIDDLE NAME	2. SOCIAL SECURITY or IDENTIFICATION NO
3. HOME ADDRESS *(Number, Street or RFD, City or Town, State, and ZIP Code)*	4. POSITION *(Title, Grade, Component)* **CIVILIAN**

5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, ADDRESS (INCLUDE ZIP CODE)
ENLISTMENT **COMMISSION** **ARMY NAVY AIR FORCE MARINE CORPS** **COAST GUARD RESERVE NATIONAL GUARD**		

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRRENTLY USED *(Follow by description of past history, if complaint exists.)*

PRESENT HEALTH:

CURRENT MEDICATIONS:

ALLERGIES (INCLUDING TO INSECT BITES/STINGS AND TO COMMON FOODS):

9. HAVE YOU EVER *(Please check each item)*

YES	NO	*(Check each item)*
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	*(Check each item)*
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or gallstones				Paralysis (include infantile)
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye truble				Adverse readtion to serum, drug or medicine				Car, train, sea or air sickness
			Ear nose, or throat trouble								Frequent trouble sleeping
			Hearing loss				Broken bones				Depression or excessive worry
			Chronic or frequent colds				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Severe tooth or gum trouble				Rupture/hernia				Nervous trouble of any sort
			Sinusitis				Piles or rectal diseases				Periods of unconsciousness
			Hay Fever				Freuent or paintful urination				
			Head injury				Bed wetting since age 12				
			Skin diseases				Kidney stone or blood in urine				
			Thyroid trouble or goiter				Sugar or albumin in urine				
			Tuberculosis				VD -- Syphilis, gonorrhea, etc				
			Asthma				Recent gain or loss of weight				
			Shortness of breath				Arthritis, Rheumatism, or Bursitis				
			Pain or pressure in chest				Bone, joint or other deformity				
			Chronic cough				Lameness				
			Palpitation or pounding heart				Loss of finger or toe	12. FEMALES ONLY: HAVE YOU EVER			
			Heart trouble or murmur				Painful or "trick" shoulder or elbow				Been treated for a female disorder
			High or low blood pressure				Recurrent back pain				Had a change in menstrual pattern
								DATE OF LMP			
								DATE OF LMP			

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU *(check one)*

☐ Right handed ☐ Left handed

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YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		15. Have you been refused employment or been unable to hold a job or stay in school because of:
		A. Sensitivity to chemicals, dust sunlight, etc.
		B. Inability to perform certain motions.
		C. Inability to assume certain positions.
		D. Other medical reasons *(If yes, give reasons.)*
		16. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*
		17. Have you ever been denied life insurance? *(If yes, state reason and give details.)*
		18. Have you ever had, or have you been advised to have, any operations? *(If yes, describe and give age at which occurred.)*
		19. Have you every been a patient in any type of hospitals? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*
		20. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*
		21. Have you consulted or been treated by clinics, physicians, healers, or othe practi-tioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hosptial, clinic, and details)*
		22. Have you ever been rejected for military service becasue of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)*
		23. Have you ever been discharged from militray service becasue of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)*
		24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disabilty? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he/she deems important, and record any significant findings here.)

QUESTIONING REVEALS	YES	NO	DETAILS
MARIJUANA USE			
OTHER DRUG ABUSE			
ALCOHOL ABUSE			

TYPED OR PRINTED NAME OF PHYSIUCIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

* U.S. Government Printing Office: 1991-643-555